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	125038	A. BUILDING: _____ B. WING _____	12/10/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALOHA NURSING & REHAB CENTRE	45-545 KAMEHAMEHA HIGHWAY KANEOHE, HI 96744

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4 000	Initial Comments A re-licensure survey was conducted from 12/05/2018 to 12/10/2018. During this survey, a complaint (ACTS #6329) was also investigated and substantiated. The facility census included 125 residents.	4 000		
4 115	11-94.1-27(4) Resident rights and facility practices Written policies regarding the rights and responsibilities of residents during the resident's stay in the facility shall be established and shall be made available to the resident, resident family, legal guardian, surrogate, sponsoring agency or representative payee, and the public upon request. A facility must protect and promote the rights of each resident, including: (4) The right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility; This Statute is not met as evidenced by: Based on observation the facility failed to provide privacy to one resident (R)123 of a sample of 44. Findings Include: On 12/04/2018 at 02:56PM observed the wound nurse (RN183) perform wound care and dressing changes of R123's pressure ulcers. The ulcers were located on R123's left thigh and leg. He also required personal care and medication application to his scrotum. When preparing for the procedure R183 attempted to pull the curtain around the bed to provide privacy. It was noted the curtains would not close all the way, leaving	4 115	Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility□s credible allegation of compliance. 1. Immediate action(s) taken for the resident(s) found to have been affected include:	1/3/19

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4 115	Continued From page 1 approximately a three-foot open space at the end of the bed. R183 was in bed one closest to the door. During the procedure the resident located in bed 2 received a visit from the therapy dog who was brought in the room by two people. Surveyor held the curtain and stood in the open space to provide privacy to R123. On 12/07/2018 surveyor requested Director of Nursing (DON) to inspect R123's room (129). At that time, it was noted the curtain in bed two also did not close all the way to provide privacy needed for that resident. DON stated, "they are missing a panel." All residents have the right to privacy, which includes during medical treatment and personal care.	4 115	Resident # 123□s privacy curtain room was reassessed on 12/04/2018 to ensure that the curtain closes all the way to provide privacy during care and treatment. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected. Identification of other residents having the potential to be affected was accomplished by: conducting facility rounds of resident rooms. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: An in-service education program was conducted by the Environmental Services Manager with all Environmental Services Staff addressing the functionality of privacy curtains and the process for reporting broken equipment. A facility wide audit of all rooms was conducted 12/4/2018 to identify and correct all privacy panel discrepancies. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: Environmental Services Manager or designee, will conduct random audits monthly for three (3) consecutive months. Findings of this audit will be reviewed by the QA Committee.	

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4 115	Continued From page 2	4 115	This plan of correction will be monitored at the monthly QA meeting until such time as consistent substantial compliance has been met.	
4 118	11-94.1-27(7) Resident rights and facility practices Written policies regarding the rights and responsibilities of residents during the resident's stay in the facility shall be established and shall be made available to the resident, resident family, legal guardian, surrogate, sponsoring agency or representative payee, and the public upon request. A facility must protect and promote the rights of each resident, including: (7) The right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive; □ This Statute is not met as evidenced by: Based on staff interview, and record review, the facility failed to obtain documentation that resident's or resident's representative was given opportunity to formulate advanced directives or had a valid Advanced Directive (AD) for Resident(R)6, R31, R53, R67, R78, R96, R117, R123, and R327, and one resident's (R67) documents had a discrepancy in content. Findings Include: 1. On Record Review (RR) review of R6, R53, R67, R78, R123, and R327 records, did not reflect documentation that the resident or resident's representative was given opportunity to	4 118	Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility□s credible allegation of compliance. 1. Immediate action(s) taken for the resident(s) found to have been affected include: R #6, 31, 53, 78, 96, 117, 123 and 327	1/3/19

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4 118	Continued From page 3 formulate advanced directives or had an AD. R67 did not have an AD and the content in the POLST, care summary and MD order did not match. On 12/05/2018 at 09:00 AM Social Work Director (SWD) was interviewed regarding the facility process related to advanced directives. She stated. "We ask on admission and we're working on a process now for follow up. We are doing an audit now." SWS validated there is not a process in place at this time for follow up after admission and said. "In the future we will document discussions in the e chart." The SWD confirmed at that time R6, R53, R67, R78, R123, and R327 did not have documentation that they or their representative was given an opportunity to formulate advanced directives or had an advance advanced directive in the medical record. On 12/05/2018, R67's chart was reviewed with the SWD, who confirmed the POLST, care summary, and MD order had a discrepancy of R67's wishes. The MD order, and care plan summary indicated "full code" (all resuscitation measures), and the POLST was marked "do not resuscitate." At on 12/07/2018 at 11:38 AM, the SWD reported, "I met with R67. She wants to be a full code, so I pulled the POLST from the record." 2. On 12/06/2018 at 09:01 AM Record review (RR) for R96 showed POLST only dated 08/20/18, no AD noted. 3. On 12/06/2018 11:42 AM review of R31, and R117 records did not reflect documentation that resident or resident's representative was given opportunity to formulate advanced directives or had an advanced directive.	4 118	were made aware of their rights to formulate an advance directive. R67 was given the opportunity to clarify discrepancy between AD and MD orders on 12/7/2018. 2. Identification of other residents having the potential to be affected was accomplished by: Determining the code status or presence/absence of Advance Directives is required for all residents. Therefore, all residents have the potential to be affected. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: Systemic change in admissions process to identify and obtain established advance directives upon admission and document same. Social Services notified of residents/resident representatives requesting information or who do not have established advance directives. A medical record audit of all residents will be completed by 01/21/2018. Discrepant findings were addressed and all needed actions will be completed by January 21st, 2019. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: For a period of three months, the Director of Social Services or designee will perform random medical record audits of new admissions. During comprehensive	

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4 118	Continued From page 4 On 12/07/2018 09:00 AM, SWD was interviewed and she validated that R31, and R117 did not have documentation that they or their representative was given opportunity to formulate advanced directive or had an advanced directive.	4 118	assessments, Social Workers will review current advance directives if in place, and offer advance directive to resident if appropriate. Results of the audits will be reviewed monthly with the QA committee until such time it is determined that substantial compliance is maintained	
4 136	11-94.1-30 Resident care The facility shall have written policies and procedures that address all aspects of resident care needs to assist the resident to attain and maintain the highest practicable health and medical status, including but not limited to: (1) Respiratory care including ventilator use; (2) Dialysis; (3) Skin care and prevention of skin breakdown; (4) Nutrition and hydration; (5) Fall prevention; (6) Use of restraints; (7) Communication; and (8) Care that addresses appropriate growth and development when the facility provides care to infants, children, and youth. This Statute is not met as evidenced by: 1. Based on record review, and interview of staff the facility failed to notify the physician immediately of R(7) significant weight loss in a month. Findings Include: On 12/05/2018 12:18 PM review of record reflected that resident weighed 150 pounds on 07/22/2018 and then weighed 140.1 pounds on 08/23/2018, a 6.6% weight loss in a month.	4 136	1) Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility□s	1/3/19

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4 136	Continued From page 5 Reviewed R7's electronic medical record for documentation that facility informed the physician immediately of the significant change in R7's weight, and the record did not reflect that the facility informed the physician immediately of resident's significant change in physical status. On 12/10/2018 08:05 AM, S(54) was interviewed who reviewed R7's electronic medical record for the 6.6% weight loss and validated that there was a significant weight loss within a month. S54 was asked to show documentation that the facility immediately informed the physician of the weight loss. S54 reviewed the electronic medical record's progress notes, and physician notes that the weight loss was reported immediately. S54 validated that the facility did not report the weight loss to the physician immediately. S54 was asked if the communication to the physician is reflected elsewhere. S54 validated that the electronic medical record was only source of documentation that would reflect communication between the facility and the physician. 2. Based on interview and record review (RR), the facility failed to ensure two residents (R) 26, and R40 of 44 sampled residents selected for review were turned/repositioned in a timely and consistent manner . This deficient practice had the potential to cause a negative outcome to a resident's physical, mental, and or psychosocial health and well-being. Findings Include: On 12/10/2018 at 11:00 AM RR of "Completed Care Task" dated 12/03/2018 through 12/10/18 provided by CIS Director6 for R26 and R40 showed large time gaps and inconsistent documentation for turning/repositioning every two	4 136	credible allegation of compliance. 1. Immediate action(s) taken for the resident(s) found to have been affected include: Resident # 7 was reweighed on 12/9/2018 to verify the weight change in facility and compared to dialysis dry weights. The physician and the resident□s representative were notified promptly the current weight was consistent with that of the post hospital weight from August 2018. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: An in-service education program will be conducted by the Director of Nursing Services or designee for all licensed staff addressing circumstances that require notification of the resident□s physician, resident□s representative by 1/21/2019. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The Director of Nursing Services, or designee, will conduct random chart audits monthly identifying and validating significant changes, and that they have been documented as reported to both	

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4 136	Continued From page 6 hours by staff for R26 and R40. On 12/10/2018 at 01:00 PM Interview with DON about the "Completed Care Task" dated 12/03/2018 to 12/10/2018 for R26 and R40 regarding the large time gaps and inconsistent documentation every two hours by staff for turning/repositioning R26 and R40. DON confirmed that staff are supposed to document very two hours that they turned/repositioned the residents. DON stated "What is not documented isn't done or possibly not done." 3. Based on interviews, observation and record review (RR), the facility failed to have a system in place to monitor the implementation of Range of Motion (ROM) exercises to one resident (R)53 of 44 sampled residents. This deficient practice has the potential to effect R53's ability to reach his identified goal of increasing independence. Findings Include: R53 diagnosis is paraplegia and requires staff assistance for all Activities of Daily Living (ADL's). During an interview with R53 on 12/05/2018 at 12:13PM observed R53 using an exercise band to stretch his left leg. Asked if he received Physical therapy (PT), and R53 stated, "I'm going to Straub for therapy." Asked R53 if facility staff did range of motion(ROM)/exercises with him to support his therapy goals. R53 replied, "CNA84 is the only one who really does it." Asked R53 if he knew how often staff was supposed to do exercises, and he replied, "No". Record review of R53's care plan revealed a goal to "become independent with ADL's." CNA's were responsible to do exercises with R53 every shift	4 136	physician and family as appropriate. Findings of this audit will be reviewed by the QA Committee. This plan of correction will be monitored at the monthly Quality Assurance meeting until such time consistent substantial compliance has been met. 2) Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facilities credible allegation of compliance. 1. Immediate action(s) taken for the resident(s) found to have been affected include: Resident # 26,40 and 123 continue to receive care and services according to their current plan of care. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all dependent residents have the potential to be affected. 3. Actions taken/systems put into place to reduce the risk of future occurrence include:	

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4 136	Continued From page 7 (three times a day). Instructions were to "assist resident with hamstring, achilles & hip adductor stretch, hold each stretch for 1-2 minutes". During an interview with CNA77 on 12/05/2018 at 02:15PM, CNA77 was observed documenting task completion. Observed several tasks highlighted in red. CNA77 explained "they turn red if they are overdue. He's (R53) stressing me now because he wants a shower. It's suppose to be done by 02:00PM. R53's care plan revealed "prefers morning showers" The task for R53's exercises was not listed. CNA77 stated, "It's not listed because I already checked it off". Asked CNA77 to explain what the task specifically said, and if she completed the exercises. CNA77 stated, "I didn't do all of them". Requested to demonstrate in R53's room what she had completed. CNA77 verbalized and motioned how she did hip adduction with R53. CNA77 stated, "I was going to do the rest of them when I got him up to shower". Asked CNA77 if any issues with staffing today, and she replied, "Yes, today we have 11 people each, and we normally have 8 or 9". Asked if it was difficult to complete all tasks, CNA77 replied "yes". During an interview with R53 on 12/06/2018 at 08:20AM, informed R53 the exercises were to be done once every shift, per day. Asked if evening and night CNA's did exercises 12/05/2019, and he replied, "No." During an interview with CNA84 on 12/07/2018 at 02:30pm, CNA84 said, "I know how important the exercises are for R53, I make sure it gets done." Asked if there was enough time to get the task done, and she said, "it is difficult sometimes, but I make sure I get it done." Asked CNA84 if R53 had expressed concern exercises were not	4 136	An in-service education program will be conducted by the Director of Nursing or designee with all direct care staff addressing the importance of turning and repositioning residents according to their plan of care by 1/21/2019. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The Director of Nursing or designee, will conduct a random audit monthly for three (3) consecutive months. Findings of this audit will be reviewed by QA Committee. This plan of correction will be monitored at the monthly QA meeting until such time consistent substantial compliance has been met. 3) Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility s credible allegation of compliance. 1. Immediate action(s) taken for the resident(s) found to have been affected include: Clarify resident's recommendations for therapy to determine frequency and	

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4 136	Continued From page 8 consistently done by other staff, and she replied," Yes, he did mention it, I do them every time I'm assigned to this unit, and sometimes even when I'm on the other area. Even if I don't have time, I find the time." Asked if the unit was short staffed today and CNA84 said, "Yes." Asked if it was hard to complete tasks, she replied, "Yes, a little, but gets harder getting people up and doing showers". On 12/10/2018, at 08:13AM, during an interview with RN Manager (RN)55 asked if she was aware that R53 verbalized he is not receiving exercises consistently, and she replied, "No". Discussed CNA documentation of exercises that included entries of exercises being completed in the middle of the night (12/03/2018 at1:00AM, 12/04/2018 at 03:03AM, 12/05/2018 at 01:27AM, and 12/07/2018 at 3:59AM). Asked R55 who was responsible to monitor and ensure the task was completed. RN55 stated, "It is the nurse assigned to R53". Asked how CNA knows what to do, how educated and to show surveyor what specifically taught for R53. RN55 stated, "we use to have a restorative program. The therapist writes the instructions and trains some people who are signed off, and staff go to them to be taught". Asked what process used now, and RN55 stated, " it's on the shift report. CNA91 was taught by our PT and is on today, he might be the best one to show you". During an interview with CNA91 on 12/10/2018 at 01:00PM, CNA91 demonstrated the exercises. Asked how the CNA's are trained. CNA91 stated, "it's kind of hard to have training on that, and R53 doesn't always allow someone to shadow. He knows exactly what needs to be done, and he talked one of the agency CNA's through it. I do tell others to let me know if they need help. A lot	4 136	duration. R#53 will be referred to in-house therapy to determine his ROM needs including safe frequency and independent activities to promote resident's personal goals for independence. 2. Identification of other residents having the potential to be affected was accomplished by: All residents of the facility who require ROM exercises as identified by the rehab department have the potential to be affected by this practice. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: Direct Care Team member in-services to re-inforce importance of completing P/ROM for all residents each shift, as well as specialty ROM as care planned will be completed by 1/21/2019. Specialty ROM will be approved by Therapy to determine appropriateness with resident's plan of care. 4 How the corrective action(s) will be monitored to ensure the practice will not recur: Director of Nurses or designee will conduct monthly audits for three (3) consecutive months. Results and findings of the audits will be reviewed by the QA Committee until such time consistent substantial compliance has been achieved as determined by the committee.	

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4 136	Continued From page 9 of the others signed off as trained are no longer here". The facility did not have a system in place to monitor staff provided ROM exercises as ordered and according to the care plan. 4. Based on interviews and record review (RR), the facility failed to provide adequate supervision and implement interventions to prevent one resident (R)78 of a sample of 44 from multiple falls. Interventions implemented were not successful putting R78 at risk for additional falls and injury. Findings Include: R78 diagnoses include: Parkinson's Disease, PTSD (Post traumatic stress disorder), with a fall history. R78 was assessed as high risk for falls with poor safety awareness. Record review (RR) completed with RN Manager (RN55) and further record review revealed R78 fell on 06/03/2018, 06/04/2018, 06/21/2018, 07/19/2018, 08/18/2018, 09/12/2018, 09/14/2018, 10/01/2018, 10/19/2018, 10/24/2018, 11/10/2018, 11/13/2018, and 11/15/2018. On 12/06/2018 at 09:06AM, during interview with RN Manager/MDS Coordinator(RN55), she stated, "I'm aware of the falls." Asked how facility reviewed falls, and interventions implemented to prevent falls for R78. RN55 stated, "After a fall, it's reviewed at IDT (interdisciplinary team) meeting. Care plan's (CP) reviewed and updated with interventions as needed." RN55 stated, "R78 has tab alarm, floor mats, and bed alarm. We don't do one to one's, but give recommendations to family, who sometimes hire someone to sit with resident if they could afford it. We had families	4 136	4) Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility s credible allegation of compliance. 1. Immediate action(s) taken for the resident(s) found to have been affected include: ANRC s Medical Director and IDT reviewed R78 s care plan and medical record to ensure that all reasonable interventions, consistent with R78 s needs, goals, care plan and current professional standards of practice are in place in order to minimize the risk of a fall if possible, and, if not, reduce the risk of negative outcome from falls. 2. Identification of other residents having the potential to be affected was accomplished by: Residents identified as high fall risk and or residents requiring supervisions have the potential to be effected. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: Nursing staff will be continue to receive	

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4 136	Continued From page 10 stay in the past, and would hire for only four hours if that's what they could afford. We do frequent visual checks. With staffing its hard sometimes." RR of R78's care plan revealed revisions with the following interventions/actions to be implemented to prevent additional falls: 06/04/2018 - "nursing to continue monitor for any changes and consult with MD as needed" 06/05/2018 - "continue with fall precautions" 06/22/2018, 07/20/2018, 10/29/2018 - "nursing to continue monitor and update MD as needed" 08/20/2018 - "nursing will monitor and consult with MD as needed" 09/14/2018 - "MD ordered lab test (UA), pending results. Nursing to continue to monitor." 09/17/2018 - "nursing staff to ensure that caution signs are removed from room promptly to free of clutter." 10/02/2018 - "nursing to ensure bed and WC (wheel chair alarms in place & working and to provide routine toileting." 10/22/2018 - "nursing to ensure res is being toileted every 2 hours" 11/14/2018 - "rehab to assess for appropriateness of picking up for Part B therapy" 11/16/2018 - "licensed nurses to monitor CNA staff for safe transfers" RR of IDT note revealed R78's 11/15/2018 fall occurred "when RN attempted to assist Resident from the wheel chair to the toilet." Interventions identified at the IDT meeting to be implemented were, "MDS to follow-up to ensure RNs are following transfer protocols. RN's to also shadow CNA staff. All other fall and injury prevention measure are in place." On 12/10/2018 at 09:00AM, during interview with	4 136	training on best practices in fall prevention and risk mitigation. IDT will discuss resident falls during Daily Standup meetings and document such in the Medical Record. Fall data will be used to analyze trends in types of falls, locations, times, and if necessary, team members involved in falls to reduce avoidable falls. 4. How the corrective action(s) will be monitored to ensure the practice will not reoccur: Audited records will be reviewed by the QA Committee until such time consistent substantial compliance has been achieved as determined by the committee. 5) Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility s credible allegation of compliance. 1. Immediate action(s) taken for the resident(s) found to have been affected include: R# 53 dressing to the suprapubic catheter continues to be changed timely.	

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4 136	Continued From page 11 RN55 inquired if she attended IDT meetings. RN55 replied, "yes." RN55/MDS coordinator asked if interventions of "MDS to follow-up to ensure RN's following transfer protocols," and "RN's shadowing the CNA staff" had been implemented, RN55 replied I can't say for 100% sure." RN55 did not have any evidence the interventions were implemented. Asked if there had been any additional education regarding transfers and if she could confirm RN's were shadowing CNA's, RN55 stated, "No, not for sure." On 12/10/2018 at 10:11AM during interview with Director of Nursing (DON) discussed R78's falls. DON stated, "We've done the low bed, matts and rounding to check on him." Asked DON for additional thoughts to prevent falls. DON stated, "Educate the staff on Parkinson's disease, and R78's condition. He doesn't have the strength to pull himself up once he moves. R78 has no control to pull himself back up. Even with all the alarms, he continues to fall. We've tried to see what position he normally turns to. Staff need to anticipate his needs." Inquired if family had been asked stay with R78, or ability to pay for a someone. DON stated, "I've personally not asked. Everything is a ripple effect of our situation." DON asked if was referring to staffing, and DON replied, "Yes." On 12/10/2018 at 10:45AM during interview with Social Worker (SW)127 discussed IDT notes he documented on 11/15/2018. SW127 documented, "MDS to follow-up to ensure RN's following transfer protocols," and "RN's shadowing the CNA staff. "Asked SW127 who was responsible to implement the interventions. SW127 replied, "that would be nursing." Asked SW127 if he could confirm the interventions were implemented.	4 136	2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that residents with suprapubic catheters have the potential to be affected. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: Nursing staff will be in-serviced on F690 and the importance of ensuring that residents with suprapubic catheter receive timely dressing changes to prevent infections by 1/21/2019 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The Director of Nursing or designee, will complete random monthly audits for three (3) consecutive months and submitted to the QA Committee. Audits will be reviewed by the QA Committee until such time consistent substantial compliance has been achieved as determined by the committee.	

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4 136	Continued From page 12 SW127 replied, "No, I don't know if the care team has done that." RR revealed R78's family attended IDT meeting on 11/15/2018. Asked SW127 if family was asked to consider staying with R78 part of the day, or able to afford a sitter. SW127 replied, "No, she works full time, and I don't think she could. I could ask." SW127 stated," I think he might be better supervised in a foster home. I discussed that with her. R78's VA (Veterans Health Administration), so there are issues with payment." IDT note documented by SW127, "IDT discussed the Resident's on-going falls and the daughter confirmed that the cause of some of the falls is likely related to hallucinations, which she states he was having prior to admission." Addendum documentation 11/15/2018, "This writer offered Section Q alternative placement options. Daughter declined to discuss at this time but agreed to approach this writer if she chooses to explore this." Reviewed Facility Assessment dated November 2018. The facility assessed themselves to have the services, and competencies to provide care to individuals with Parkinson's, PTSD and with the conditions of "falls since admission or prior assessment." R78 had been assessed to be an appropriate resident for the facility. Facilities are obligated to provide adequate supervisions to prevent accidents. Adequate is based on type and frequency of individual's needs. Despite implementation of routine interventions, the facility did not provide the supervision and implement precautions to prevent R78 from falling. 5. Based on interviews and observation, the	4 136		

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4 136	Continued From page 13 facility failed to provide timely treatment to one resident (R)53 of a sample of 44. R53's wet suprapubic catheter dressing was not changed timely. Because of this deficient practice R53 was at risk to develop skin problems associated with moisture from irritation to skin breakdown or infection. Findings Include: On 12/10/2018 at 08:20AM during interview with R53, he stated, "I need a dressing change, it's soaked." Observed R53's suprapubic urinary catheter dressing was wet. R53 said, "it's (catheter) been leaking. I was supposed to get it changed this morning, but changed the appointment." Follow up at 12:00PM, R53 stated, "I just got it (dressing) changed. The nurse popped in earlier and said she didn't forget me, but didn't come back until just now." On 12/10/18 at 01:41PM during interview with RN25, discussed R53's dressing. Asked if she was aware R53 waited for dressing change this morning. RN25, replied "Yes, I just changed it." Shared R53 stated he waited a long time. RN25 replied, "Yes, quite a while." Confirmed with RN25 it took over three and a half hours to change R53's dressing. RN25 stated, "That was because of my poor time management."	4 136		
4 137	11-94.1-36(a) Admission, transfer, and discharge (a) There shall be written policies and procedures available to staff, residents, and the public that govern: (1) All services provided by the facility; and (2) The admission, transfer, and discharge	4 137		1/3/19

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4 137	Continued From page 14 of residents. This Statute is not met as evidenced by: Based on Record Review (RR), policy review, and interview, the facility failed to provide the resident and/or their representatives a written summary of the baseline care plan within 48 hours of admission to three Residents(R) (R67, R123, and R327) of a sample size of 44. A comprehensive care plan was not developed in place of the baseline care plan. Findings Include: RR of R57, R123, and R327 revealed baseline care plans were developed, but there was no evidence of documentation a written copy of the care plan was provided to the resident or resident representative. During an interview on 12/07/2018 at 11:00PM with RN Manager (RN55)/MDS coordinator, she stated " The MDS coordinators do the baseline care plans on admission. We are working on that process now as a group." RN55 confirmed written baseline care plan summaries were not provided to R67, R123, and R327 or their representative. RN55 was not aware of the details of the timeline for implementation of the new process. The facility policy titled "Comprehensive Resident Centered Care Plan-Baseline Care Plan" was reviewed. "Guideline number 3 states, "The facility must provide the resident and/or their representative with a written summary of the baseline care plan." The written summary of the baseline care plan is intended to promote communication among residents and/or representatives and caregivers.	4 137	Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility□s credible allegation of compliance. 1. Immediate action(s) taken for the resident(s) found to have been affected include: R57 has discharged home. Comprehensive care plans are in place for R123 and R327, thus deactivating the Baseline Care plan. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: All interdisciplinary care plan team members responsible for writing baseline care plans will be re-educated on the	

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4 137	Continued From page 15 It actively engages the resident and/or representative in his or her care planning. It identifies the initial goals for the resident, current medications, dietary instructions, and services/treatments to be administered.	4 137	facility'□s policy and procedure for developing Baseline Care Plans, which includes procedures for providing the resident with a summary of their baseline care plan. MDS Coordinators and/or designees will conduct an audit of all residents affected by January 21, 2019. After ensuring accuracy and current applicability, Baseline Care Plans will be provided to the resident or resident□s representative. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The Director of Nursing (DON), or designee, will complete random monthly audits of baseline care plans for three (3) consecutive months. Random audits will be completed to ensure that baseline care plan summaries are being provided to new residents, and documented in the medical record. Audit records will be reviewed by the QA Committee until such time consistent substantial compliance has been achieved as determined by the committee. Audit results will be shared with the QA Committee for comment and suggestions.	
4 148	11-94.1-39(a) Nursing services (a) Each facility shall have nursing staff sufficient in number and qualifications to meet the nursing needs of the residents. There shall be at least one registered nurse at work full-time on the	4 148		1/3/19

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4 148	Continued From page 16 day shift, for eight consecutive hours, seven days a week, and at least one licensed nurse at work on the evening and night shifts, unless otherwise determined by the department. This Statute is not met as evidenced by: Based on interviews and observation, the facility failed to provide sufficient nursing staff to provide nursing and related services to assure resident safety and as determined by resident assessments and individual plans of care. This deficiency puts the residents at risk of accidents and is a barrier to attain the highest practicable physical, mental and psychosocial wellbeing. Findings Include: Cross reference tag 0684. Based on interview and record review (RR), the facility failed to ensure three residents (R) 26, R40, and R123 were turned/repositioned according to their individualized care plan. Cross reference tag 0688. Based on interviews, observation and record review (RR), the facility failed to have a system in place to monitor the implementation of Range of Motion (ROM) exercises to one resident (R)53. Cross reference tag 0689. Based on interviews and record review RR, the facility failed to provide adequate supervision of one resident R78 resulting in 13 times during the period of June 1, 2018 and December 1, 2018. Cross reference tag 0755. Based on interviews, RR and facility policy, the facility failed to administer medications in a timely manner for R53.	4 148	Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility□s credible allegation of compliance. 1. Immediate action(s) taken for the resident(s) found to have been affected include: R26,40,123 continue to receive care and services according to their plan of care. R78□s plan of has been reviewed and revised to ensure residents□ safety. R53 continue to receive medications in a timely manner. 2. Identification of other residents having the potential to be affected was accomplished by: All residents have the potential of been affected by inadequate staffing. 3. Actions taken/systems put into place to	

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4 148	Continued From page 17 1. On 12/05/2018 at 10:00AM, resident council interview was conducted. Several residents expressed concerns there was not enough CNA's and a lot of agency. The residents reported there were mostly agency nurses on nights. The residents reported this is not a new problem, and the staff work shorthanded a lot, with Nurses called in to do CNA work. Residents felt agency nurses don't know them, have argued with them, and don't know what to do. Residents feel pay might be the reason there is not enough CNA's. Resident expressed concern about going to the bathroom alone which might result in a fall. Residents felt they had to wait to get dressed and go to the bathroom. Review of the Resident Council Minutes dated October 11, 2018 revealed discussion on staffing with facility respresentatives. On 12/07/18 at 02:30 PM observed Director of Nursing(DON) working on staffing for the remainder of the day. During interview, DON stated, "I mandated one of the RN's to stay. It's facility policy. We can mandate the RN's but not the CNA's or LPN's because they are union." Asked it the facility was using agency to supplement staffing, and she replied, "recently a lot at night." Informed DON staffing was a concern brought up at resident council interview. And if DON was aware of concerns. She stated, "They feel agency don't really know them. I know one resident had a medication they wanted to be given at a certain time, and wasn't being done. Basically, they don't know what's going on." On 12/10/18 at 09:43 AM during interview with DON, shared she had been observed on the unit assisting nursing staff throughout the survey. Asked what she did when on the unit. DON replied, "Running to get coffee, putting residents	4 148	reduce the risk of future occurrence include: The facility will continue to assess the need for staffing at least weekly by Administrative Assistant/Staffing and the Director of Nursing (DON) or designee. The facility will continue with its recruitment efforts to ensure that adequate staff is available. Administrative Assistant/Staffing will continue to communicate to DON staffing concerns so appropriate interventions can be implemented to ensure the needs of the residents are met. 4. How the corrective action(s) will be monitored to ensure the practice will not reoccur: The Director of Nursing /Designee will check with Administrative Assistant/Staffing weekly and as needed to ensure the staffing is adequate to provide care and services for the residents. Trending will be reported to QA committee until such a time that it is determined that substantial compliance is met.	

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4 148	Continued From page 18	4 148		

on the toilet, repositioning, talking with them and getting to know them. Rounds, checking safety and environment of room, assist with meals. I've been coming in on weekends quite a bit." Asked DON if the staffing situation was the reason she was doing that, and she replied, "Yes, we do have a lot of new grads, but just finishing training." Discussed agency use and asked DON if residents had expressed any concerns about agency staff or if there were any incidents reports. DON replied, "I would have to look. Nursing staff are uncomfortable with some of the agency staff. There are some we didn't bring back. Just don't feel safe with them here." Asked DON for specifics of safety concerns, and she replied, "Labeling, prepouring medications. Not comfortable doing a procedure. We requested three or four not to return due to concerns. Missed meds, not giving medication." Asked DON if she would define all of those as competency issues, and she replied, "Yes, and I have done numerous reviews of 5 rights. (right medication, right dose, right time, right person, right route)."

On 12/10/2918 at 09:04AM interviewed Administrative Assistant(AA), whose responsible for the schedule the past two years. Vacancies reviewed with AA. AA stated, "Yes, there are a lot of vacancies with CNA's." The CNA vacancies were confirmed to be as follows:
Day shift has seven open positions for CNA's, and two staff off due to workman's compensation.
Evening shift has six vacant positions, five staff off on workman's compensation and one on temporary disability.
Night shift has no vacant positions with one staff off on workman's compensation.
Asked AA what strategies were done to provide needed staff. She replied, "We are offering bonus and double pay for picking up shifts. We can't

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4 148	Continued From page 19 mandate LPN, s or CNA's. We can mandate RN's and have been doing that. They get compensated, but I'm sure it frustrates some. Some of them don't mind. Sometimes the RN's work as a CNA." Asked status of RN staffing. AA replied, "the struggle feels like it is with the CNA's. "Asked if they had contracts with more than one agency, and AA said, "Yes, and we just added another agency." Inquired if reports were generated to the quality committee on the hours of agency use.AA replied, "that would be HR (Human Resources). We have a lot more now, there's a lot." On 12/06/2018 at 10:00AM Interview with CNA90 12/06/2018, asked if they were short staff today, and CNA90 stated. "Yes, CNA's. We are suppose to have 8, and we have 5. Asked if able to complete all tasks, CNA90 stated, "if you have good teamwork." On 12/07/2018 at 07:53AM, observed no staff in or around the nursing station. The phone rang 26 times without being answered. Observed a visitor at the end of the nursing station, who waited for a while and left after no one was available. The facility is aware of the staffing situation, and documentation of turnover rate has improved. (CNA 52% January 1-June 30, 2017 to 18.8% June 11-December 10, 2018 and RN 45.16% January 1-June 30, 2017 to 10.9% June 11-December 10, 2018.) Although facility reduced turnover rate, monitored staffing, and implemented several strategies, there was not sufficient and competent staff to provide tasks of positioning, administering medications in a timely manner, monitoring residents to prevent accidents, and routine care.	4 148		

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4 159	Continued From page 20	4 159		
4 159	11-94.1-41(a) Storage and handling of food (a) All food shall be procured, stored, prepared, distributed, and served under sanitary conditions. (1) Dry or staple food items shall be stored above the floor in a ventilated room not subject to seepage or wastewater backflow, or contamination by condensation, leakages, rodents, or vermin; and (2) Perishable foods shall be stored at the proper temperatures to conserve nutritive value and prevent spoilage. This Statute is not met as evidenced by: Based on observation and interview, the facility failed to label an opened bag of frozen chicken tenders sitting on the shelf of the walk-in freezer. This deficient practice had the potential to put residents at risk for serious complications from foodborne illness as a result of their compromised health status. Findings Include: On 12/05/2018 at 08:10 AM Initial tour of kitchen with Kitchen Manager (Mgr) 135 revealed a half full opened clear plastic bag of frozen chicken tenders with no labels of any kind such as open or used-by date in the walk-in freezer. Mgr135 asked one of the cooks in the kitchen when and what meal the chicken tenders were used, the cook stated she did not know. Mgr135 told the cook she needs to throw it out. Mgr135 confirmed the chicken tenders should have been labeled or thrown out.	4 159	Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility□s credible allegation of compliance. 1. Immediate action(s) taken for the resident(s) found to have been affected include: Food and Nutritional Services Manager discarded item same day 12/05/2018. Staff members were promptly in-serviced on proper dating, labeling and storage techniques.	1/3/19

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4 159	Continued From page 21	4 159	2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents who consume food by mouth have the potential to be affected. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: All Food & Nutritional Services staff will be in-serviced on the facility'□s policies and practice guideline for maintaining safe storage practices by 1/21/2019. Kitchen wide audit completed of all storage areas on 1/21/2019. Items not properly labeled and dated will be promptly discarded at the time identified. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The Food & Nutritional Services Manager or designee will complete random monthly audits for three (3) consecutive months. Results will be reviewed by the QA Committee until such time consistent substantial compliance has been met.	
4 185	11-94.1-46(b) Pharmaceutical services (b) A facility shall have a current pharmacy policy manual consistent with current pharmaceutical practices developed and approved by the pharmacist, medical director/medical advisor, and	4 185		1/3/19

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	125038	A. BUILDING: _____ B. WING _____	12/10/2018

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4 185	Continued From page 22 director of nursing that: (1) Includes policies and procedures, and defines the functions and responsibilities relating to pharmacy services, including the safe administration and handling of all drugs and self-administration of drugs. Policies and procedures shall include pharmacy functions and responsibilities, formulary, storage, administration, documentation, verbal and telephone orders, authorized personnel, recordkeeping, and disposal of drugs; (2) Is reviewed at least every two years and revised as necessary to keep abreast of current developments in overall drug usage; and (3) Has a drug recall procedure that can be readily implemented. This Statute is not met as evidenced by: Based on interviews, Record Review (RR) and facility policy, the facility failed to administer medications in a timely manner for one resident (R)53 of a sample size of 44. Schedules are developed for administering medications to maximize effectiveness, and to prevent potential significant medication interactions. On 12/05/2018 at 12:28PM during an Interview with R53, he stated, "I'm not getting my 8AM medications on time." Inquired how often this occurred, and how long it took to get the 8AM medications. R53 stated, "It happens a lot. Sometimes it's two hours." A sample of R53's 8AM medications were reviewed for timeliness of administration. R53 was to receive Augmentin 1 tablet (Antibiotic for	4 185	Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. 1. Immediate action(s) taken for the resident(s) found to have been affected include: R53 continues to receive their medications in a timely fashion.	

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4 185	Continued From page 23 infection), and Soma (to treat pain) 1 tablet at 08:00AM. The administration history revealed the following times the 08:00AM dose of Augmentin was administered: 11/27/2018 09:18AM 11/30/2018 10:40AM 12/03/2018 10:40AM 12/05/2018 09:20AM 12/09/2018 10:07AM The administration history revealed the following times the 08:00AM dose of Soma was administered: 11/28/2018 09:24AM 11/30/2018 10:40AM 12/03/2018 10:40AM 12/05/2018 09:20AM 12/10/2018 09:08AM The facility policy/procedure titled, "Pharmacy services-Medication administration" was reviewed. The policy statement is: "Medications shall be administered in a safe and timely manner and as prescribed." Guideline 4 states, "Medications must be administered within one (1) hour of their prescribed time, unless otherwise specified." The facility did not administer R53's medications in a timely manner. They did not follow standard of practice which includes administration at the correct time. In addition they did not meet the time range identified (within one hour) in their policy.	4 185	2. Identification of other residents having the potential to be affected was accomplished by: All residents with daily routine medication orders have the potential to be affected by this practice. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: Licensed Nursing Staff will be in-serviced by the DON/designee regarding the facility policy on medication administration 1/21/2019. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: DON or designee will conduct random audits. Audit results will be reviewed by the QA Committee until such time consistent substantial compliance has been achieved as determined by the committee.	
4 204	11-94.1-53(b)(1) Infection control	4 204		1/3/19

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4 204	Continued From page 24 (b) The facility shall have provisions for isolating residents with infectious diseases until appropriate transfers can be made. (1) The facility shall have a written policy that outlines proper isolation and infection control techniques and practices; This Statute is not met as evidenced by: Based on observation, staff interview, and review of facility policy, the facility failed to exchange the suction equipment/cannister for two of twenty five residents (Resident (R) 74, and R11) reviewed. This deficient practice put the residents at risk for the development and transmission of communicable diseases and infections. Findings Include: 1. During an observation of the suction equipment in R74's room, on 12/05/2018 at 09:41 AM, the suction equipment cannister contained approximately 50cc of white liquid contents. The cannister was not marked with any date, as required by facility, and there was no way to tell when the contents were collected and how long the suctioned cannister was in use. 2. During an observation of the suction equipment in R11's room, on 12/05/2018 at 09:44 AM, the suction equipment cannister contained approximately 200cc of clear/white liquid contents. The cannister was marked with the date 11/20/2018. However, this would mean that the suction equipment has been in use for 15 days and overdue to be changed out. After staff interview with Registered Nurse (RN) 20 and review of facility policy, the suction equipment/cannister for both R74 and R11 should	4 204	Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility□s credible allegation of compliance. 1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice Suction canister in R74'□s room removed, replaced with a properly labeled canister upon identification. Suction canister in R11□'s room removed, replaced with a properly labeled canister upon identification. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice.	

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4 204	Continued From page 25 have been replaced after one week of use. Also, RN 20 acknowledged that the contents should have been properly discarded. After review of the facility policy on Suction Machine, the policy stated "The suction canister is to be completely clean and dry before storing". As previously mentioned, the facility follows a process to change out the suction cannisters every week or on the 7th day. Again, this was not done. Based on observation, staff interview, and policy review, the facility failed to maintain Contact Precautions (as ordered by the Physician) for R79. This deficient practice put other residents, staff, and visitors at risk of being exposed to R79's known illness of Methicillin-resistant Staphylococcus aureus (MRSA). Findings Include: 1. During an observation of R79, on 12/06/2018 at 08:16 AM, Certified Nurse Assistant (CNA) 101 was noted to have entered R79's room without donning gloves or wearing a gown; as required for residents on Contact Precautions. CNA101 was also noted to have had direct contact with R79's bedside table and call bell. Also, it was observed that hand hygiene was not done by CNA101 upon exiting the room. Upon questioning CNA101 on 12/06/2018 at 08:20 AM, CNA101 stated that R79 was on Contact Precautions and acknowledged that a gown and gloves should have been used upon the previous entry to the room. CNA101 went on to say that it was confusing because there was no "isolation cart" outside of R79's room. CNA101 then stated that the isolation cart would be	4 204	All residents using suction machines with canisters are at risk. 3. What measures will be put into place or systematic changes made to ensure that the deficient practice will not recur Licensed Team members in-serviced to re-inforce importance of dating and labeling canister for infection control purposes by 1/21/2019. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of the systematic changes. The Director of Nursing, or designee, will conduct random monthly audits for three (3) consecutive months. Findings of these audits will be reviewed by the QA Committee. his plan of correction will be monitored at the monthly QA meeting until such time consistent substantial compliance has been met. 2) 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? All team members caring for R79 were in-serviced on the importance of donning PPE before entering resident□'s room on 12/6/2018.	

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4 204	Continued From page 26 obtained and placed outside the room. During review of facility policy on Transmission-Based Precautions, it stated "Use of personal protective equipment (PPE); Gloves, a. Wear gloves whenever touching the resident's intact skin or surfaces and articles in close proximity to the resident (e.g. medical equipment, bed rails). b. Don gloves upon entry into the room or cubicle. Gowns, a. Wear a gown whenever anticipating that clothing will have direct contact with the resident or potentially contaminated environmental surfaces or equipment in close proximity to the resident. Don gown upon entry into the room or cubicle. Remove gown and observe hand hygiene before leaving the resident-care environment. b. After gown removal, ensure that clothing and skin do not contact potentially contaminated environmental surfaces that could result in possible transfer of microorganism to other residents or environmental surfaces".	4 204	2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? The facility has determined that all residents have the potential to be affected. 3. What measure will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? Employees will be in-serviced on contact precautions, room signage and facility requirements by 1/21/2019. Annual skills checklists for direct care givers on proper infection control procedure will include PPE use and door signage, and preventing the spread of infection. Proper PPE use and infection control procedure is also incorporated into new hire orientation. 4. How will the corrective action be monitored to ensure the deficient practice will not recur? The Director of Nursing , or designee, will complete random observations of rooms with precautions signs. Findings of this audit will be reviewed by the QA Committee. This plan of correction will be monitored at the monthly QA meeting until such time consistent substantial compliance has	

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4 204	Continued From page 27	4 204	been met.	
4 243	11-94.1-64(a) Engineering and maintenance (a) The facility shall maintain all essential mechanical, electrical, and resident care equipment in safe operating condition. This Statute is not met as evidenced by: Based on observation, review of policy and procedure, staff interview, and review of the Laundry Dryer Cleaning Logs, the facility failed to clean out the dryer lint traps on 22 out of the 59 days reviewed. As a result of this deficient practice, the facility put the safety of the residents, staff, and the public at risk for hazards such as a fire. Findings include: A review of facility policy on Laundry Guidelines, Dryer Lint Traps, it stated "Dryer Lint Traps. Dryer lint traps are cleaned after each drying cycle". During an observation of the laundry room on 12/10/2018 at 09:48 AM, the lint trap for dryer #2 was noted to be full of lint. According to the Materials Manager (Mgr) 167, the lint traps are to be cleaned three times per shift and employees are to initial the cleaning log after the cleaning has been performed. A review of the Laundry Dryer Lint Trap Cleaning Log revealed no entries on 22 out of the 59 days reviewed. Accordingly, this meant that the cleaning of the dryer lint traps were not done on the 22 days. On 12/10/2018 at 10:00 AM, Mgr167	4 243	Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility□s credible allegation of compliance. 1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice; No specific residents identified as being affected. 3. What measures will be put into place or systematic changes made to ensure that the deficient practice will not recur; and Log revised to include specific time. Team members in-serviced 12/10/2018 on new Dryer Lint Trap Cleaning Log which now includes date and specific time	1/3/19

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4 243	Continued From page 28 acknowledged that there were no initials on the 22 days, and that there was a risk for hazards such as a fire.	4 243	4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of the systematic changes. Environmental Services Manager or Designee will conduct monthly audits for three (3) consecutive months. Results of audits will be reported to QA Committee for review. Audits will continue to be reported until such a time that substantial compliance is in place and further close monitoring is no longer needed.	